

**New Jersey Department of Banking and Insurance
Valuation Bureau
P.O. Box 325
Trenton, NJ 08625-0325**

**APPLICATION PACKAGE FOR
LICENSURE AND CERTIFICATION AS AN ORGANIZED DELIVERY SYSTEM (ODS)**

Application Checklist for ODS Certification or Recommendation for License

Please use this checklist to complete the application package. Refer to N.J.A.C. 8:38B-2.2, 2.3 and 2.4 for more detailed instructions. (Applicants for license should refer also to regulations under Title 11 of the New Jersey Administrative Code.) Applications should be mailed to: ODS Certification at the above address or delivered to: New Jersey Department of Banking and Insurance, Valuation Bureau, 20 West State Street, 11th Floor, Trenton, NJ 08625.

**Part A
(N.J.A.C. 8:38B-2.3)**

- ☐ 1. A completed Application Cover Sheet
- ☐ 2. A completed Irrevocable Consent to Jurisdiction of the Commissioners and New Jersey Courts
- ☐ 3. A completed Appointment of Attorney for the State of New Jersey (all applicants; for license, appoint the Commissioner of the Department of Banking and Insurance)
- ☐ 4. A completed Financial Risk Affidavit (applicants for certification only)
- ☐ 5. A copy of the ODS's basic organizational documents, as defined at N.J.A.C. 8:38B-1.2
- ☐ 6. A copy of the ODS's executed by-laws, plan of operation, rules and regulations, or similar documents intended to regulate the conduct of the ODS's internal affairs
- ☐ 7. A Biographical Affidavit completed for each of the individuals who are, or are intended to be, responsible for the conduct of the affairs of the ODS, including: i) members of the ODS's board of directors, executive committee or other governing board or committee; ii) the ODS's principal officers, and medical director, if applicable; iii) any person who owns or has the right to acquire 10 percent or more of the voting securities of the ODS; iv) each person that has loaned funds to the ODS for the operation of the ODS's business; and v) partners or members, in the case of a partnership or association
- ☐ 8. A business plan consisting of:
 - i) an organizational chart of the ODS;
 - ii) a narrative description of the ODS, its facilities, and personnel, and the health care services to be offered by the ODS to a carrier;
 - iii) a list of the geographical areas in which the described health care services are to be performed and approximate number of each type of provider who will provide the health care services;
 - iv) a description of any administrative services for which the ODS shall be responsible on behalf of the carrier;
 - v) a list of any affiliate of the ODS that provides services to the ODS in New Jersey and a description of any material transaction between the affiliate and

- the ODS;
 - vi) a description of any arrangements between the ODS and any other ODS or subcontractor for services associated with the provisions of health care services;
 - vii) a description of any reinsurance or stop loss arrangements;
 - viii) a plan, in the event of insolvency of the ODS, for continuation of the health care services to be provided in accordance with existing contracts and laws;
 - ix) a description of the means by which the ODS will be compensated under contracts with carriers;
 - x) a description of the arrangement for the ODS reporting of data to the carriers and a description of the carrier's oversight responsibility.
- ☐ 9. A specimen copy of all provider agreements made or intended to be executed between the ODS and providers
- ☐ 10. A specimen copy of all contracts made or intended to be executed between the ODS and any other ODS or subcontractor for services associated with the provision of health care services
- ☐ 11. A specimen copy of all management agreements made or to be executed between the ODS and one or more carriers
- ☐ 12. A list of all administrative, civil or criminal actions and proceedings to which the ODS, its affiliates, or persons who are responsible for the conduct of the affairs of the ODS or affiliate, have been subject, including a statement regarding the resolution of such actions and proceedings.
- ☐ 13. A list of the carriers with which the ODS has contracted or intends to execute a contract pending the approval of the application
- ☐ 14. A list of all states in which the ODS has been or currently is doing business as described in the application
- ☐ 15. The appropriate fee set forth at N.J.A.C. 8:38B-2.9

Part B
(N.J.A.C. 8:38B-2.4)

- ☐ 1. Services for which certification is being sought (please check all that apply):
 - ☐ 1) Performance of one or more types of health care services delivery
 - ☐ 2) Network management
 - ☐ 3) Credentialing and recredentialing
 - ☐ 4) Utilization management development
 - ☐ 5) Utilization management application
 - ☐ 6) Utilization management appeals
 - ☐ 7) Member complaints
 - ☐ 8) Provider complaints
 - ☐ 9) Continuous quality improvement
- ☐ 2. For performance of one or more types of health care services delivery:
 - ☐ a) List of names of all providers by county, municipality, zip code, and services
 - ☐ b) Map of the service area identifying the location of the participating providers

- ☐ c) Criteria to assure the availability and accessibility of services to be performed
- ☐ 3. For network management:
- ☐ a) Demonstration of adequacy of the network for services offered in relation to population to be served consistent with standards of N.J.A.C. 8:38B-3.5
 - ☐ b) Demonstration of the CQI program
 - ☐ c) Demonstration of the complaint and appeal system for providers
 - ☐ d) Demonstration of the provider participation panel
 - ☐ e) Demonstration of the hearing panel for provider terminations
 - ☐ f) Demonstration of records maintenance procedures and standards
 - ☐ g) Credentialing and recredentialing standards
 - ☐ h) Statement of deficiencies and POCs with respect to licensed facilities
- ☐ 4. For credentialing and recredentialing:
- ☐ a) Policies and procedures demonstrating compliance with N.J.A.C. 8:38B-3.6
 - ☐ b) Designated medical director and his/her functions
 - ☐ c) Explanation of linkage and coordination with the CQI and complaint systems of the carrier(s) and/or their other contractor(s), including flow chart(s)
- ☐ 5. For utilization management development:
- ☐ a) Policies and procedures for developing protocols and guidelines, demonstrating compliance with N.J.A.C. 8:38B-3.7
 - ☐ b) Designated medical director and his/her functions
 - ☐ c) Copy of the protocols and guidelines developed, and instructions for use
- ☐ 6. For performance of utilization management:
- ☐ a) Policies and procedures, demonstrating compliance with N.J.A.C. 8:38B-3.8
 - ☐ b) Designated medical director and his/her functions
 - ☐ c) Explanation of medical director's oversight, if employed by the carrier
 - ☐ d) Explanation of the UM criteria used
- ☐ 7. For utilization management appeals:
- ☐ a) Policies and procedures, demonstrating compliance with N.J.A.C. 8:38B-3.9
 - ☐ b) Designated medical director and his/her functions
 - ☐ c) Flow chart demonstrating communication and decision-making, if the medical director is employed by the carrier
 - ☐ d) Specimens of letters regarding appeal rights and decisions on appeals to be sent to both covered persons and providers.
- ☐ 8. For member complaints:
- ☐ a) Policies and procedures, demonstrating compliance with N.J.A.C. 8:38B-3.12
 - ☐ b) Explanation of linkage and coordination with the CQI and complaint system of the carrier(s) and/or their other contractor(s)
 - ☐ c) Explanation of how complaints are segregated among carriers (and other clients)
 - ☐ d) Specimens of the letters regarding complaint and complaint resolution to be sent to covered persons and providers acting on behalf of covered persons

- ☐ 9. For provider complaints:
 - ☐ a) Policies and procedures, demonstrating compliance with N.J.A.C. 8:38B-3.11
 - ☐ b) Explanation of linkage and coordination with the CQI and complaint system of the carrier(s) and/or their other contractor(s)
 - ☐ c) Explanation of how complaints are segregated among carriers (and other clients)
 - ☐ d) Specimens of the letters regarding a complaint and complaint resolution to be sent to providers.
- ☐ 10. For continuous quality improvement:
 - ☐ a) Policies and procedures, demonstrating compliance with N.J.A.C. 8:38B-3.10
 - ☐ b) Explanation of linkage and coordination with the complaint systems and other continuous quality improvement components that the carrier(s) may have
 - ☐ c) Designated medical director and his/her functions

Part C
(N.J.A.C. 8:38B-2.2)

- ☐ 1. Application in 3-ring binder(s), labeled with the ODS' name, and serially numbered, if necessary
- ☐ 2. Application tabbed, exhibits segregated, and shown in order requested in regulations
- ☐ 3. All pages numbered
- ☐ 4. All specimen contracts contain unique identifier in lower left corner of each page
- ☐ 5. Payment by check or money order made payable to the "Treasurer, State of New Jersey"
- ☐ 6. No items left blank

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**APPLICATION PACKAGE FOR
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APPLICATION COVER SHEET**

1. Type of Application: <input type="checkbox"/> Licensure <input type="checkbox"/> Certification	2. Name of Applicant
3. Physical Address of Applicant: _____ _____ _____	4. Mailing Address: _____ _____ _____
5. Organizational Information <input type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Professional Corporation <input type="checkbox"/> Professional Association <input type="checkbox"/> Other	
6. Provide a brief description of the services that the applicant will be providing:	
7. City and State of Incorporation (if applicable) City: _____ State: _____	
8. Federal Employer Identification Number _____ or Social Security Number _____	
9. Contact Person Information: Name: _____ Title: _____ Telephone Number: _____ Toll-Free Number: _____ Fax Number: _____ E-mail Address: _____	
10. Resident Status - Resident of New Jersey? <input type="checkbox"/> Yes <input type="checkbox"/> No	County in which Home Office is located for NJ Residents
<p style="text-align: center;">Certification</p> <p>I, <i>(Name and Title):</i> _____ certify that I am authorized to file this certification on behalf of the applicant, the information set forth in the enclosed application and herein is true to the best of my information, knowledge and belief, and that the Department of Banking and Insurance may rely on the information set forth in the application and herein in determining whether to grant a license or certificate pursuant to <u>N.J.S.A. 17:48H-1 et seq.</u> I further certify that the applicant is familiar and will comply with the requirements set forth in <u>N.J.S.A. 17:48H-1 et seq.</u> and rules promulgated pursuant thereto.</p>	
Full Legal Name of Applicant (Type or Print)	Title
Signature of Applicant	Date

**IRREVOCABLE CONSENT TO JURISDICTION OF THE COMMISSIONER
AND NEW JERSEY COURTS**

THE STATE OF _____ }
COUNTY OF _____ } KNOW ALL MEN BY THESE PRESENTS:

That _____ of
(Name of Applicant)
_____ is filing herewith its application for
(Domiciliary City and State)
certificate to operate as an organized delivery system in the State of New Jersey;

That, upon issuance of said certificate by the Commissioner of Banking and Insurance,
_____ shall consent to the jurisdiction of
(Name of Applicant)
the Commissioner of Banking and Insurance and all New Jersey courts in relation to any transactions
or other activity subject to regulation under N.J.S.A. 17B:48H-1 et seq. and all other applicable New
Jersey statutes or rules; and

That such consent to the jurisdiction of the Commissioner of Banking and Insurance and
the New Jersey courts shall be and remain irrevocable for as long as
_____ possesses a certification from the
(Name of Applicant)
Commissioner of Banking and Insurance or engages in business as an organized delivery system in
or from the State of New Jersey, and until all contractual obligations in the State of New Jersey are
satisfied.

Witness our hands and the impress of the seal of said applicant, this _____ day of
_____, 20 _____.

(Corporate Seal-if applicable)

Attest:

Signature of President
(or authorized representative)

(Print or Type Name)

Signature of Secretary
(or authorized representative)

(Print or Type Name)

Appointment of Attorney for the State of New Jersey

KNOW ALL MEN BY THESE PRESENTS: That the _____
of the _____ of _____
in the _____ of _____,
desiring to do business in the State of New Jersey in conformity with the laws thereof, hereby,
constitutes and appoints the Commissioner of Banking and Insurance of New Jersey, and his or her
successor in office, to be its true and lawful Attorney, upon whom all original process in any action
or legal proceeding against said _____
may be served. And the said _____
hereby stipulates and agrees that any original process against it, which is served upon said Attorney,
shall be of the same legal force and validity as if served upon said _____,
and that the authority of said Attorney shall continue in force irrevocable so long as any liability of said
_____ remains outstanding in New Jersey.

IN WITNESS WHEREOF, the said _____
has caused these presents to be subscribed by its President, and attested by its Secretary, and its
corporate seal to be hereunto affixed, this _____ day of _____,
20 _____.

(Corporate Seal-if applicable)

Attest:

Signature of President
(or authorized representative)

(Print or Type Name)

Signature of Secretary
(or authorized representative)

(Print or Type Name)

FINANCIAL RISK AFFIDAVIT

(Print or Type)

I, _____, _____,
(Name of Officer) (Title)

an officer of _____ being duly authorized to
(Name of ODS)

provide this affidavit on behalf of _____, do
(Name of ODS)

hereby attest and affirm that _____, does not
(Name of ODS)

engage in the acceptance of the transfer of financial risk from any carrier as defined by N.J.S.A.
17:48H-1 et. seq., and rules promulgated pursuant thereto and shall not accept a transfer of financial
risk from any carrier until such time as _____
(Name of ODS)

becomes licensed by the New Jersey Department of Banking and Insurance. Further, I attest and
affirm that the compensation arrangement(s) set forth in this application do not constitute the transfer
of financial risk.

Dated and signed this _____ day of _____, 20 _____ at
_____. I hereby certify under penalty of perjury that I am
acting on my own behalf, and that the foregoing statements are true and correct to the best of my
knowledge and belief.

(Signature of Affiant)

State of _____

County of _____

Personally appeared before me the above named _____
(Name of Officer of ODS)

personally known to me, who, being duly sworn, deposes and says that he executed the above
instrument and that the statements and answers contained therein are true and correct to the best of
his knowledge and belief.

Subscribed and sworn to before me this _____ day of _____, 20 _____.

(Notary Public)

My Commission Expires _____

BIOGRAPHICAL AFFIDAVIT

(Print or Type)

Full Name and Address of Applicant *(Do not use Group Names)*:

In connection with the above-named applicant, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS 'NO' OR 'NONE', SO STATE.

1. Affiant's Full Name* (Initials not acceptable)

2. Have you ever had your name changed?

☐ Yes ☐ No

If Yes, give the reason for the change.

- a) Other names used at any time.

3. Date of Birth

Place of Birth

4. Affiant's Business Address

Business Telephone

**BIOGRAPHICAL AFFIDAVIT
(Continued)**

5. List your residences for the last ten (10) years starting with your current address.*

<u>Date</u>	<u>Street Address, City and State</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

*These items may be submitted on a separate form to maintain confidentiality.

6. Education (Dates, Names, Locations and Degrees).

a) College

b) Graduate Studies

c) Others

7. List of memberships in professional societies and associations.

8. Present or proposed position with the applicant.

**BIOGRAPHICAL AFFIDAVIT
(Continued)**

9. List complete employment record (up to and including present jobs, positions, directorates or officerships) for the past twenty (20) years:

<u>Date</u>	<u>Employer Name and Address</u>	<u>Title</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Present employer may be contacted: ☐ Yes ☐ No
Former employers may be contacted. ☐ Yes ☐ No

11. Have you ever been in a position that required a fidelity bond?

☐ Yes ☐ No

If any claims were made on the bond, give details:

- a) Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

☐ Yes ☐ No

If yes, give details:

12. List any professional, occupational and vocational licenses issued by any public or governmental licensing agency or regulatory authority which you presently hold or have held in the past (provide date license issued, issuer of license, date terminated, reasons for termination).

**BIOGRAPHICAL AFFIDAVIT
(Continued)**

13. During the last ten (10) years, have you ever been refused a professional, occupational or vocational license by any public or governmental licensing agency or regulatory authority, or has any such license held by you ever been suspended or revoked?

☐ Yes ☐ No

If yes, give details:

14. List any insurers, prepaid dental plans, health service corporations or health maintenance organizations, in which you control directly or indirectly or own legally or beneficially 10% or more of the outstanding stock (in voting power).

If any of the stock is pledged or hypothecated in any way, give details:

15. Will you or members of your immediate family subscribe to or own, beneficially or of record, shares of stock of the applicant-organized delivery system or its affiliates?

☐ Yes ☐ No

If any of the shares or stock are pledged or hypothecated in any way, give details:

16. Have you ever been adjudged a bankrupt?

☐ Yes ☐ No

17. Have you ever been convicted or had a sentence imposed or suspended or had pronouncement of a sentence suspended or been pardoned for conviction of or pleaded guilty or nolo contendere to an information or indictment, charging any felony, or charging a misdemeanor involving embezzlement, theft, larceny or mail fraud, or charging a violation of any corporate securities statute or any insurance law, or have you been a subject of any disciplinary proceedings of any federal or state regulatory agency?

☐ Yes ☐ No

If yes, give details:

**BIOGRAPHICAL AFFIDAVIT
(Continued)**

- a) Has any company been so charged, allegedly as a result of any action or conduct on your part?

☐ Yes ☐ No

18. Have you ever been an officer, director, trustee, investment committee member, key employee or controlling stockholder of any insurer, prepaid dental plans, health service corporations or health maintenance organizations, which, while you occupied such a position or capacity with respect to it, became insolvent or was placed under supervision or in receivership, rehabilitation, liquidation or conservatorship?

☐ Yes ☐ No

19. Has the certificate of authority or license to do business of any insurer, prepaid dental plans, health service corporations or health maintenance organizations, of which you were an officer or director or key management person ever been suspended or revoked while you occupied such position?

☐ Yes ☐ No

If yes, give details:

Dated and signed this _____ day of _____, 20____ at _____
_____. I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

(Signature of Affiant)

State of _____

County of _____

Personally appeared before me the above-named _____
personally known to me, who, being duly sworn, deposes and says that he executed the above instrument and that the statements and answers contained therein are true and correct to the best of his knowledge and belief.

Subscribed and sworn to before me this _____ day of _____, 20____.

(Notary Public)

My Commission Expires _____